		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035188

Facility Name: Lexington Health Care Center-Bloomingdale

Address: 165 S. Bloomingdale Road (Number) Bloomingdale (City) 60108 (Zip Code)

County: DuPage

Telephone Number: (630) 980-8700 **Fax #** (630) 980-6170

IDPA ID Number: 363635151001

Date of Initial License for Current Owners: 05/01/89

Type of Ownership:

	VOLUNTARY,NON-PROFIT			X	PROPRIETARY			GOVERNMENTAL
	Charitable Corp.				Individual			State
	Trust				Partnership			County
IRS Exemption Code					Corporation			Other
				X	"Sub-S" Corp.			
					Limited Liability Co.			
					Trust			
					Other			

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	172	Skilled (SNF)	172	62,780	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	172	TOTALS	172	62,780	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,142	5,216	7,306	30,664	8
9	SNF/PED					9
10	ICF	16,256	2,769	171	19,196	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,398	7,985	7,477	49,860	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.42%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 5/1/89

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New construction NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 48 and days of care provided 6,497

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	253,678	30,363	12,348	296,389		296,389		296,389			1
2	Food Purchase		202,966		202,966		202,966	(8,466)	194,500			2
3	Housekeeping	248,227	27,044		275,271		275,271	300	275,571			3
4	Laundry	38,067	16,279		54,346		54,346	(5,937)	48,409			4
5	Heat and Other Utilities			153,903	153,903		153,903	3,003	156,906			5
6	Maintenance	45,103		120,425	165,528		165,528	3,189	168,717			6
7	Other (specify):*											7
8	**TOTAL General Services**	585,075	276,652	286,676	1,148,403		1,148,403	(7,911)	1,140,492			8
	B. Health Care and Programs											
9	Medical Director			4,313	4,313		4,313		4,313			9
10	Nursing and Medical Records	2,395,964	180,655	62,035	2,638,654		2,638,654		2,638,654			10
10a	Therapy			594,308	594,308		594,308		594,308			10a
11	Activities	145,881	10,689	2,332	158,902		158,902		158,902			11
12	Social Services	94,076		8,790	102,866		102,866		102,866			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,635,921	191,344	671,778	3,499,043		3,499,043		3,499,043			16
	C. General Administration											
17	Administrative	151,550		329,061	480,611		480,611	(329,061)	151,550			17
18	Directors Fees											18
19	Professional Services			52,807	52,807		52,807	5,356	58,163			19
20	Dues, Fees, Subscriptions & Promotions			19,106	19,106		19,106	658	19,764			20
21	Clerical & General Office Expenses	428,777	28,513	24,644	481,934		481,934	13,215	495,149			21
22	Employee Benefits & Payroll Taxes			521,041	521,041		521,041	61,150	582,191			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,859	3,859		3,859	2,279	6,138			24
25	Other Admin. Staff Transportation			2,160	2,160		2,160	7,527	9,687			25
26	Insurance-Prop.Liab.Malpractice			147,164	147,164		147,164	2,948	150,112			26
27	Other (specify):*											27
28	**TOTAL General Administration**	580,327	28,513	1,099,842	1,708,682		1,708,682	(235,928)	1,472,754			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,801,323	496,509	2,058,296	6,356,128		6,356,128	(243,839)	6,112,289			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Lexington Health Care Center-Bloomingdale #0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			62,131	62,131		62,131	186,970	249,101			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,589	11,589		11,589	298,400	309,989			32
33	Real Estate Taxes							114,579	114,579			33
34	Rent-Facility & Grounds			1,073,102	1,073,102		1,073,102	(1,073,102)				34
35	Rent-Equipment & Vehicles			2,404	2,404		2,404	3,268	5,672			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,149,226	1,149,226		1,149,226	(469,885)	679,341			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		170,998		170,998		170,998		170,998			39
40	Barber and Beauty Shops			14,103	14,103		14,103		14,103			40
41	Coffee and Gift Shops			1,767	1,767		1,767		1,767			41
42	Provider Participation Fee			94,170	94,170		94,170		94,170			42
43	Other (specify):* **Nonallowable Costs**			55,151	55,151		55,151	(55,151)				43
44	**TOTAL Special Cost Centers**		170,998	165,191	336,189		336,189	(55,151)	281,038			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,801,323	667,507	3,372,713	7,841,543		7,841,543	(768,875)	7,072,668			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(5,937)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(32)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(933)	43		13
14	Non-Care Related Interest	(3,000)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(479)	43		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(37,326)	43		24
25	Fund Raising, Advertising and Promotional	(9,923)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,319)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	100,328			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 39,379		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(808,254)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (808,254)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (768,875)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188
1/1/03 - 12/31/03

Schedule A

Schedule VI. Adjustment detail
Line 29, Other

Description	Amount	Reference
Nonallowable collections	(312)	19
Nonallowable professional fees	(3,107)	19
Offset miscellaneous income	(5,448)	21
Unrealized gain resulting from interest rate swap	115,888	43
Deferred maintenance amortization	1,279	6
Disallow radiology	(4,976)	43
Disallow laboratory	(2,710)	43
Disallow out of period legal fees	(286)	19
Total	100,328	

See Accountants' Compilation Report

STATE OF ILLINOIS

Lexington Health Care Center-Bloomingdale

ID# 0035188

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	300	0	0	0	0	0	0	0	0	300	3
4	Laundry	(5,937)	0	0	0	0	0	0	0	0	0	0	(5,937)	4
5	Heat and Other Utilities	0	0	3,003	0	0	0	0	0	0	0	0	3,003	5
6	Maintenance	0	0	1,910	0	0	0	0	0	0	0	0	1,910	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,937)	0	5,213	0	0	0	0	0	0	0	0	(724)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	(329,061)	0	0	0	0	0	0	0	(329,061)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	154	8,907	0	0	0	0	0	0	0	0	9,061	19
20	Fees, Subscriptions & Promotions	0	0	658	0	0	0	0	0	0	0	0	658	20
21	Clerical & General Office Expenses	0	50	18,613	0	0	0	0	0	0	0	0	18,663	21
22	Employee Benefits & Payroll Taxes	0	0	52,684	0	0	0	0	0	0	0	0	52,684	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	2,279	0	0	0	0	0	0	0	0	2,279	24
25	Other Admin. Staff Transportation	0	0	0	7,527	0	0	0	0	0	0	0	7,527	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	2,948	0	0	0	0	0	0	0	2,948	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	204	83,141	(318,586)	0	0	0	0	0	0	0	(235,241)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,937)	204	88,354	(318,586)	0	0	0	0	0	0	0	(235,965)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	162,406	0	24,564	0	0	0	0	0	0	0	186,970	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,032)	301,158	0	274	0	0	0	0	0	0	0	298,400	32
33	Real Estate Taxes	0	113,102	0	1,477	0	0	0	0	0	0	0	114,579	33
34	Rent-Facility & Grounds	0	(1,073,102)	0	0	0	0	0	0	0	0	0	(1,073,102)	34
35	Rent-Equipment & Vehicles	0	0	0	3,268	0	0	0	0	0	0	0	3,268	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,032)	(496,436)	0	29,583	0	0	0	0	0	0	0	(469,885)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(51,980)	(111,373)	0	0	0	0	0	0	0	0	0	(163,353)	43
44	**TOTAL Special Cost Centers**	(51,980)	(111,373)	0	0	0	0	0	0	0	0	0	(163,353)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(60,949)	(607,605)	88,354	(289,003)	0	0	0	0	0	0	0	(869,203)	45

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Sambell of Bloomingdale		
See attached Schedule B		See attached Schedule B		Limited Partnership	Bloomingdale	Real estate ptsp.
				Royal Mgmt. Corp	Lombard	Mgmt. Co.
				Lexington Financial		
				Services, L.L.C.	Lombard	Finance Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental expense	$ 1,073,102	Sambell of Bloomingdale Limited Partnership	**	$	$ (1,073,102)	1
2	V	19	Professional fees		Sambell of Bloomingdale Limited Partnership	**	154	154	2
3	V	21	Bank charges		Sambell of Bloomingdale Limited Partnership	**	50	50	3
4	V	30	Depreciation		Sambell of Bloomingdale Limited Partnership	**	162,406	162,406	4
5	V	32	Interest expense		Sambell of Bloomingdale Limited Partnership	**	296,527	296,527	5
6	V	32	Amortization of mortgage costs		Sambell of Bloomingdale Limited Partnership	**	4,631	4,631	6
7	V	33	Property taxes		Sambell of Bloomingdale Limited Partnership	**	113,102	113,102	7
8	V	43	State replacement tax		Sambell of Bloomingdale Limited Partnership	**	4,515	4,515	8
9	V	43	Unrealized gain		Sambell of Bloomingdale Limited Partnership	**	(115,888)	(115,888)	9
10	V								10
11	V								11
12	V				** Certain owners of Lexington Health Care Center of Bloomingdale, Inc. own 100%				12
13	V				of Sambell of Bloomingdale Limited Partnership				13
14	Total			$ 1,073,102			$ 465,497	$ * (607,605)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188
1/1/03 - 12/31/03

Schedule B

VII. Related Parties
Owners

Name	Ownership %
James Samatas Discretionary Trust	22.33%
John Samatas Discretionary Trust	22.33%
Cynthia Thiem Discretionary Trust	22.34%
Jeffrey J. Bell Revocable Trust	8.25%
Lawrence W. Bell Revocable Trust	8.25%
David S. Bell Revocable Trust	8.25%
David S. Bell 2001 Trust	2.75%
Jeffrey J. Bell 2001 Trust	2.75%
Lawrence W. Bell 2001 Trust	2.75%

VII. Related Parties
Related Nursing Homes

Name of facility	City
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping supplies	$	Royal Management Corp.	**	$ 300	$ 300	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	2,949	2,949	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	54	54	17
18	V	6	Repairs & maintenance		Royal Management Corp.	**	1,855	1,855	18
19	V	6	Scavenger & exterminating		Royal Management Corp.	**	55	55	19
20	V	19	Computer consultant & supplies		Royal Management Corp.	**	6,711	6,711	20
21	V	19	Professional fees		Royal Management Corp.	**	2,196	2,196	21
22	V	20	Advertising - help wanted		Royal Management Corp.	**	149	149	22
23	V	20	Dues & subscriptions		Royal Management Corp.	**	509	509	23
24	V	21	Bank charges		Royal Management Corp.	**	2,580	2,580	24
25	V	21	Office supplies & printing		Royal Management Corp.	**	5,893	5,893	25
26	V	21	Postage		Royal Management Corp.	**	2,651	2,651	26
27	V	21	Telephone		Royal Management Corp.	**	7,489	7,489	27
28	V	22	FICA		Royal Management Corp.	**	23,795	23,795	28
29	V	22	FUTA		Royal Management Corp.	**	427	427	29
30	V	22	SUTA		Royal Management Corp.	**	740	740	30
31	V	22	Insurance - W/C		Royal Management Corp.	**	451	451	31
32	V	22	Insurance - hospitalization		Royal Management Corp.	**	23,517	23,517	32
33	V	22	401(k) and other emp. benefits		Royal Management Corp.	**	3,754	3,754	33
34	V	24	Travel & seminar		Royal Management Corp.	**	2,279	2,279	34
35	V								35
36	V								36
37	V								37
38	V		**Certain owners of Lexington Health Care Center of Bloomingdale, Inc. own 100% of Royal Management Corp.						38
39	Total			$			$ 88,354	$ * 88,354	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	25	Auto expense	$	Royal Management Corp.	**	$ 7,527	$ 7,527	15
16	V	26	Insurance general		Royal Management Corp.	**	2,948	2,948	16
17	V	30	Depreciation - vehicles		Royal Management Corp.	**	2,611	2,611	17
18	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	6,104	6,104	18
19	V	30	Depreciation - equipment		Royal Management Corp.	**	15,849	15,849	19
20	V	32	Interest		Royal Management Corp.	**	274	274	20
21	V	33	Property taxes		Royal Management Corp.	**	1,477	1,477	21
22	V	35	Equipment rental		Royal Management Corp.	**	3,268	3,268	22
23	V	17	Management Fees	329,061	Royal Management Corp.	**		(329,061)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		**Certain owners of Lexington Health Care Center of Bloomingdale, Inc. own 100% of Royal Management Corp.						38
39	Total			$ 329,061			$ 40,058	$ * (289,003)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdal # 0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	22.33%	See Schedule C	4	10%	Salary	$ 27,234	L17, C1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33%	See Schedule C	2	8%	Salary	17,021	L17, C1	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34%	See Schedule C	1	6%	Salary	13,617	L17, C1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	10%	Salary	4,085	L17, C1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	3	6%	Salary	10,383	L17, C1	5
6											6
7											7
8				All individuals worked in excess of 40 hours per week							8
9											9
10											10
11											11
12											12
13								TOTAL	$ 72,340		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188
1/1/03 - 12/31/03

Schedule C

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

Name of facility	John Samatas	James Samatas	Cynthia Thiem	George Samatas	Jason Samatas	Total
Lexington Health Care Center of Chicago Ridge, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of Elmhurst, Inc.	14,844	23,751	11,875	3,563	9,055	63,088
Lexington Health Care Center of LaGrange, Inc.	10,787	17,259	8,629	2,589	6,580	45,844
Lexington Health Care Center of Lake Zurich, Inc.	20,089	32,143	16,071	4,821	12,254	85,378
Lexington Health Care Center of Lombard, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of Orland Park, Inc.	26,721	42,748	21,376	6,413	16,298	113,556
Lexington Health Care Center of Schaumburg, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of Streamwood, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of Wheeling, Inc.	21,870	34,993	17,496	5,249	13,342	92,950
Total	182,979	292,766	146,383	43,915	111,617	777,660

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	737,665	10	$ 3,521	$	62,780	$ 300	1
2	5	Utilities - gas & electric	Bed Days	737,665	10	34,652		62,780	2,949	2
3	5	Utilities - water & sewer	Bed Days	737,665	10	635		62,780	54	3
4	6	Repairs & maintenance	Bed Days	737,665	10	21,802		62,780	1,855	4
5	6	Scavenger & exterminating	Bed Days	737,665	10	648		62,780	55	5
6	19	Computer consultant & supplies	Bed Days	737,665	10	78,852		62,780	6,711	6
7	19	Professional fees	Bed Days	737,665	10	25,806		62,780	2,196	7
8	20	Advertising - help wanted	Bed Days	737,665	10	1,748		62,780	149	8
9	20	Dues & subscriptions	Bed Days	737,665	10	5,976		62,780	509	9
10	21	Bank charges	Bed Days	737,665	10	30,319		62,780	2,580	10
11	21	Office supplies & printing	Bed Days	737,665	10	69,243		62,780	5,893	11
12	21	Postage	Bed Days	737,665	10	31,145		62,780	2,651	12
13	21	Telephone	Bed Days	737,665	10	87,995		62,780	7,489	13
14	22	FICA	Bed Days	737,665	10	279,595		62,780	23,795	14
15	22	FUTA	Bed Days	737,665	10	5,021		62,780	427	15
16	22	SUTA	Bed Days	737,665	10	8,695		62,780	740	16
17	22	Insurance - W/C	Bed Days	737,665	10	5,294		62,780	451	17
18	22	Insurance - hospitalization	Bed Days	737,665	10	276,319		62,780	23,517	18
19	22	401(k) and other emp. benefits	Bed Days	737,665	10	44,113		62,780	3,754	19
20	24	Travel & seminar	Bed Days	737,665	10	26,781		62,780	2,279	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,038,160	$		$ 88,354	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	737,665	10	$ 88,444	$	62,780	$ 7,527	1
2	26	Insurance - general	Bed Days	737,665	10	34,634		62,780	2,948	2
3	30	Depreciation - vehicles	Bed Days	737,665	10	30,679		62,780	2,611	3
4	30	Depreciation - leasehold improv.	Bed Days	737,665	10	71,727		62,780	6,104	4
5	30	Depreciation - equipment	Bed Days	737,665	10	186,226		62,780	15,849	5
6	32	Interest	Bed Days	737,665	10	3,219		62,780	274	6
7	33	Property taxes	Bed Days	737,665	10	17,360		62,780	1,477	7
8	35	Equipment rental	Bed Days	737,665	10	38,401		62,780	3,268	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 470,690	$		$ 40,058	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lexington Financial						$	$			$	1
2	Services, L.L.C.	X		Mortgage	Varies	2/1/96	5,575,000	4,513,750	02/01/2026	Variable	296,527	2
3												3
4												4
5												5
	Working Capital											
6	Shareholders	X		Working Capital	None	Various	744,845	125,539	07/05/04	0.0200	3,000	6
7	Lasalle Bank N. A.		X	Working Capital	Varies	04/06/02	750,000		04/04/04	Prime	8,589	7
8												8
9	TOTAL Facility Related						$ 7,069,845	$ 4,639,289			$ 308,116	9
	B. Non-Facility Related*											
10								Amortization of mortgage costs			4,631	10
11								Interest Income offset			(32)	11
12								Management company allocation			274	12
13								Nonallowable shareholder interest			(3,000)	13
14	TOTAL Non-Facility Related						$	$			$ 1,873	14
15	TOTALS (line 9+line14)						$ 7,069,845	$ 4,639,289			$ 309,989	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$ 126,000	1
	Allocated from Management Company	1,477	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2002	$ 125,102	2
3. Under or (over) accrual (line 2 minus line 1).		$ 579	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 114,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 114,579	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	114,528	8
1999	114,820	9
2000	116,303	10
2001	119,600	11
2002	125,102	12

2002 tax assessment (not included):	1,672,090	
Equalization factor:	1.0396	
Tax rate:	0.06543	
Est. 2003 tax payable '04	113,737.28	
Use:	114,000	

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity**

This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington Health Care Center-Bloomingdal COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0035188

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-15-401-003	Land and building	$ 125,102.00	$ 125,102.00
2.	Royal Management Corp. (Samvest of Lombard II)		$	$
3.	05-01-202-019		$ 212,239.00	$ 1,477.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 337,341.00	$ 126,579.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,554 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	43,000	1987	$ 402,548	1
2	Management Company allocation			13,578	2
3	TOTALS	43,000		$ 416,126	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	88		1989	1989	$ 2,980,863	$	35	$ 85,192	$ 85,192	$ 1,249,483	4
5	9		1992	1992	178,974		35	5,114	5,114	61,365	5
6	75		1994	1994	2,022,894		35	57,797	57,797	549,071	6
7											7
8											8
	Improvement Type**										
9	Capitalized repairs			1989	9,080		10			9,080	9
10	Building Improvements			1990	3,674		10			3,674	10
11	Building Improvements			1991	2,586		10			2,586	11
12	Building Improvements			1992	3,154		10			3,154	12
13	Building Improvements			1993	1,582	79	10	79		1,582	13
14	Building Improvements			1994	15,734	1,573	10	1,573		14,948	14
15	Land Improvements			1994	1,381	138	10	138		1,312	15
16	Land Improvements			1995	1,074		15	72	72	608	16
17	Building Improvements			1995	1,288		35	37	37	239	17
18	Building Improvements			1995	9,433	270	35	270		2,295	18
19	Building Improvements			1995	43,839	1,252	35	1,252		10,642	19
20	Concrete flooring, fire doors, tile, sprinkler heads,										20
21	and basement renovation			1996	8,706	298	10-35	298		2,238	21
22	Land Improvements - drain tile system			1996	7,858		15	524	524	3,929	22
23	Resident room heaters			1997	3,563	102	35	102		713	23
24	Automatic doors			1997	12,950	370	35	370		2,251	24
25	Basement renovation			1997	58,806	5,936	10	5,936		36,604	25
26	Land Improvement - outdoor flagpoles			1997	1,574	105	15	105		682	26
27	1st Floor Remodel (Nurses Station/Lounge)			1998	76,487	7,649	10	7,649		42,068	27
28	Wiring for MDS			1998	4,506	451	10	451		2,479	28
29	Flag Pole			1998	787	79	10	79		433	29
30	Resurface/Stripe Parking Lot			1998	9,777	978	10	978		5,377	30
31	Kitchen tile/paint			1999	718	72	10	72		323	31
32	1st Floor Remodel			1999	3,296	330	10	330		1,648	32
33	Roof repairs			2000	5,748	383	15	383		1,341	33
34	Sump pump			2000	2,534	253	10	253		887	34
35	Sump pump basin repair			2000	6,307	631	10	631		2,208	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Automatic door closers	2000	$ 1,300	$ 87	15	$ 87	$	$ 303	37
38	Infrared curtains for elevator doors	2001	3,000	300	10	300		750	38
39	Ejector pump	2002	3,050	610	5	610		1,169	39
40	Lift station pump	2002	3,359	672	5	672		896	40
41	New asphalt parking lot	2003	16,450	274	10	274		274	41
42	Roof repairs	2003	2,900	24	10	24		24	42
43	Freezer/cooler repairs	2003	4,005	83	20	83		83	43
44	Kitchen remodel	2003	7,188	150	20	150		150	44
45	Painting/wallpaper/carpeting	2003	59,512	2,976	20	2,976		2,976	45
46	Floor tile	2003	16,305	815	20	815		815	46
47	Rehab-painting & decorating	2003	75,774	316	20	316		316	47
48	Rehab-floor tile	2003	8,117	34	20	34		34	48
49	Dining room remodel	2003	42,698	178	20	178		178	49
50									50
51	Foundation repair	2003	4,800	100	20	100		100	51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59	Leasehold improvements - management company	1995	8,606		35	255	255	2,090	59
60	Leasehold improvements - management company	1996	7,004		35	208	208	1,501	60
61	Leasehold improvements - management company	1989	241		31	7	7	121	61
62	HVAC - management company	1998	181		35	5	5	31	62
63	Offices - management company	1999	458		35	14	14	59	63
64	Land improvements - management company	2002	21,400		15	634	634	2,734	64
65	Building - management company	2002	166,493		40	4,939	4,939	7,978	65
66	HVAC, electrical, security system - management company	2003	1,650		30	42	42	42	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,933,664	$ 27,568		$ 182,408	$ 154,840	$ 2,035,844	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 423,395	$ 30,913	$ 44,585	$ 13,672	5-10 years	$ 289,676	71
72	Current Year Purchases	99,755	3,648	3,648		5-10 years	3,648	72
73	Fully Depreciated Assets	241,227					241,227	73
74	Allocated from Mgmt. Co.	152,396		15,849	15,849		50,505	74
75	TOTALS	$ 916,773	$ 34,561	$ 64,082	$ 29,521		$ 585,056	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79	Allocated from Mgmt. Co.			25,465		2,611	2,611		20,332	79
80	TOTALS			$ 25,465	$	$ 2,611	$ 2,611		$ 20,332	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,292,028	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 62,129	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 249,101	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 186,972	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,641,232	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 5,672 Description: Postage meter: $141; Copier: $2,263; Allocated from management company: $3,268
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES [X] NO
   It is the policy of this facility to only hire certified nurses aides.
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	4,516	$ 233,573	$	4,516	$ 233,573	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		497	56,356		497	56,356	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		4,461	301,844		4,461	301,844	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				170,998		170,998	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Wound Therapy	L10A, C3				2,535			2,535	13
14	TOTAL			$	9,474	$ 594,308	$ 170,998	9,474	$ 765,306	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (8,528)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 514,356)	1,792,261	1,792,261	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,541	22,541	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	73,542	72,371	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,879,816	$ 1,887,173	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	53,269	53,269	12
13	Land		416,126	13
14	Buildings, at Historical Cost		5,182,731	14
15	Leasehold Improvements, at Historical Cost	525,600	750,933	15
16	Equipment, at Historical Cost	400,805	942,238	16
17	Accumulated Depreciation (book methods)	(326,647)	(2,641,232)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized Loan Costs		82,034	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 653,027	$ 4,786,099	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,532,843	$ 6,673,272	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 379,815	$ 379,815	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	125,539	125,539	29
30	Accrued Salaries Payable	151,102	151,102	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,238	3,238	31
32	Accrued Real Estate Taxes(Sch.IX-B)		114,000	32
33	Accrued Interest Payable		37,334	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	557,910	230,360	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,217,604	$ 1,041,388	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,513,750	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Interest Rate Swap		373,482	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,887,232	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,217,604	$ 5,928,620	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,315,239	$ 744,652	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,532,843	$ 6,673,272	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188
1/1/03 - 12/31/03

Schedule E

XV. Balance Sheet
C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
P/A Audit Settlement	104,258	104,258
Accrued PTP	49,720	49,720
Accrued Rent	327,550	
Accrued 401 (k) contribution	10,239	10,239
Due from related party	29,115	29,115
Other accrued expenses	37,028	37,028
Total line 36	557,910	230,360

XVII. Income Statement
E. Other Revenue

28. Other Revenue

Description	Amount
Miscellaneous income	5,448
Investment income in Lexington Financial Services, L.L.C	446
Total line 28	5,894

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 763,721	1
2	Restatements (describe):		2
3			3
4			4
5	Rounding	(2)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 763,719	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	551,520	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 551,520	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,315,239	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,629,545	1
2	Discounts and Allowances for all Levels	(681,785)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,947,760	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	993,162	6
7	Oxygen	35,896	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,029,058	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,788	12
13	Barber and Beauty Care	15,469	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	33	15
16	Rental of Facility Space		16
17	Sale of Drugs	281,401	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	105,691	21
22	Laundry	5,937	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 410,319	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	32	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 32	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**See attached Schedule E**	5,894	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,894	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,393,063	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,148,403	31
32	Health Care	3,499,043	32
33	General Administration	1,708,682	33
	B. Capital Expense		
34	Ownership	1,149,226	34
	C. Ancillary Expense		
35	Special Cost Centers	242,019	35
36	Provider Participation Fee	94,170	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,841,543	40
41	**Income before Income Taxes (line 30 minus line 40)****	551,520	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 551,520	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity files a cash basis tax return

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,212	2,282	$ 90,580	$ 39.69	1
2	Assistant Director of Nursing	2,199	2,304	67,523	29.31	2
3	Registered Nurses	39,123	41,904	1,173,386	28.00	3
4	Licensed Practical Nurses	3,185	3,410	83,767	24.57	4
5	Nurse Aides & Orderlies	70,690	74,756	859,723	11.50	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,654	10,507	120,985	11.51	8
9	Activity Director	2,034	2,188	29,959	13.69	9
10	Activity Assistants	11,710	12,260	115,922	9.46	10
11	Social Service Workers	4,533	4,832	94,076	19.47	11
12	Dietician	1,558	1,616	21,807	13.49	12
13	Food Service Supervisor	2,001	2,413	36,688	15.20	13
14	Head Cook	2,047	2,142	23,357	10.90	14
15	Cook Helpers/Assistants	12,611	13,150	78,978	6.01	15
16	Dishwashers	11,148	12,034	92,848	7.72	16
17	Maintenance Workers	2,626	3,001	45,103	15.03	17
18	Housekeepers	34,454	36,974	248,227	6.71	18
19	Laundry	5,502	5,950	38,067	6.40	19
20	Administrator	1,750	2,092	79,210	37.86	20
21	Assistant Administrator					21
22	Other Administrative	550	553	72,340	130.81	22
23	Office Manager					23
24	Clerical	19,138	21,815	428,777	19.66	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	238,725	256,183	$ 3,801,323 *	$ 14.84	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	43	$ 11,579	L1, C3	35
36	Medical Director	29	4,313	L9, C3	36
37	Medical Records Consultant	15	725	L10, C3	37
38	Nurse Consultant	10	2,906	L10, C3	38
39	Pharmacist Consultant	12	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	2,332	L11, C3	44
45	Social Service Consultant	49	2,240	L12, C3	45
46	Other(specify)				46
47	Religious Consultant	Monthly	6,550	L12, C3	47
48					48
49	TOTAL (lines 35 - 48)	170	$ 31,845		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	665	$ 13,291	L10, C3	50
51	Licensed Practical Nurses	81	1,452	L10, C3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	745	$ 14,743		53

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kimberly Goodall	Administrator	0%	$ 43,565
Patrick Scales	Administrator	0%	35,645
John Samatas	Admin/Plant Ops	22.33%	17,021
James Samatas	Administrative	22.33%	27,234
Cynthia Thiem	Administrative	22.34%	13,617
George Samatas	Administrative	0%	4,085
Jason Samatas	Administrative	0%	10,383
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 151,550

B. Administrative - Other

Description	Amount
	$
Management fees (eliminated in column 7)	329,061
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 329,061

C. Professional Services

Vendor/Payee	Type	Amount
ING	401(k) Administration	$ 870
Altschuler, Melvoin & Glasser LLP	Accounting	20,635
American Express Tax & Bus. Svcs.	Accounting	5,710
Katten, Muchin, Zavis, Rosenman	Legal	3,678
James Samatas	Legal	162
Personnel Planners	U/C Consulting	1,545
Carol Jeschke	Staffing Consultant	823
Sachnoff & Weaver	Legal	10,380
See attached Schedule F		9,004
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 52,807

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,704
Unemployment Compensation Insurance	33,793
FICA Taxes	273,195
Employee Health Insurance	190,187
Employee Meals	8,466
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Contribution	12,385
Other employee benefits	5,461
TOTAL (agree to Schedule V, line 22, col.8)	$ 582,191

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	16,103
Health Care Worker Background Check	
(Indicate # of checks performed 83)	1,000
Miscellaneous Permits & Fees	969
Miscellaneous Dues & Subscriptions	1,034
Allocated from management company	658
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,764

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,859
Seminar Expense	
Allocated from management company	2,279
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,138

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188
1/1/03 - 12/31/03

Schedule F

XIX. Support Schedules
C. Professional Services

Vendor/Payee		
eHealth Solutions	Computer Consulting	1,080
Information Controls Inc.	Computer Consulting	865
Answers On Demand	Computer Consulting	2,654
Krakau Business	Computer Consulting	493
Action Computer Service, Inc.	Computer Consulting	346
Gigatrend	Computer Consulting	195
Moody Investor Services	Financial Consulting	(550)
Amalgamated	Bond Consulting	441
Freedman, Anselmo & Lindberg	Collections	312
Gilson, Labus & Silverman	Operations Consulting	60
Various Consultants	Various Consulting	3,108
		9,004
Total, Agrees to Schedule V, Line 19, Column 3		52,807
Allocated from management co.		
American Express Tax & Business Services	Accounting	479
Personnel Planners	U/C Consulting	20
Gilson, Labus and Silverman	Accounting	43
James Samatas	Legal	59
Katten, Muchin, Zavis and Rosenman	Legal	56
Sachnoff and Weaver	Legal	435
ING / Pension Administrators	401 (k) Administration	587
Various	Computer Consulting	6,711
Various	Consulting	517
Allocated from building partnership		
James Samatas	Annual report	154
Nonallowable legal fees		
Freedman, Anselmo & Lindberg	Collections	(312)
Various	Collections	(3,107)
Katten, Muchin, Zavis and Rosenman	Out of period legal fees	(286)
Total, Agrees to Schedule V, Line 19, Column 8		58,163

See accountants' compilation report.

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Painting & Decorating	Various, 2000	$ 7,676	3	$ 1,279	$ 2,559	$ 2,559	$ 1,279	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 7,676		$ 1,279	$ 2,559	$ 2,559	$ 1,279	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/03 Ending: 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **44,005** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **94,170**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **8,466** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Lexington Health Care 12:21 PM 11/4/2005**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS		COMPARE C	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-768,875	equal to	-768,875	0	O.K.		Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	309,989	equal to	309,989	0	O.K.		Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	114,579	equal to	114,579	0	O.K.		Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	ok	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	249,101	equal to	249,101	0	O.K.		Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.		Pg14 L20+N:	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	5,672	equal to	5,672	0	O.K.		Pg14 J30+N	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.		Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.		Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	591,773	equal to	594,308	-2,535	FAILED	ok, wound therapy on schedule D	Pg16 Z12+Z1	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	170,998	equal to	#VALUE!	#VALUE!	#VALUE!		Pg16 V32	N/A	14	6	Pg4 F22 + P	N/A	39,10a	2
Income Stat. General Serv.	1,148,403	equal to	1,148,403	0	O.K.		Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	3,499,043	equal to	3,499,043	0	O.K.		Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstatior	1,708,682	equal to	1,708,682	0	O.K.		Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	1,149,226	equal to	1,149,226	0	O.K.		Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	242,019	equal to	242,019	0	O.K.		Pg19 P17	N/A	35	2	Pg4 H21..H2	N/A	38to41+43	4
Income Stat. Prov. Partic.	94,170	equal to	94,170	0	O.K.		Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,395,964	equal to	2,395,964	0	O.K.		Pg20 K11..K1	A.	5,24,25,27-3	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.		Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.		Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	145,881	equal to	145,881	0	O.K.		Pg20 K19+K2	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	94,076	equal to	94,076	0	O.K.		Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	253,678	equal to	253,678	0	O.K.		Pg20 K22..K	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	45,103	equal to	45,103	0	O.K.		Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	248,227	equal to	248,227	0	O.K.		Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	38,067	equal to	38,067	0	O.K.		Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	151,550	equal to	151,550	0	O.K.		Pg20 K30..K	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	428,777	equal to	428,777	0	O.K.		Pg20 K33..K	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.		Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	3,801,323	equal to	3,801,323	0	O.K.		Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	11,579	< or = to	12,348	-769	O.K.	ok, dietary supplies included	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	4,313	< or = to	4,313	0	O.K.		Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	19,574	< or = to	62,035	-42,461	O.K.	ok, physical rehab	Pg20 X14..X	B. & C.	o39 and 50t	2	Pg3 G19	N/A	10	3
Activity Consultant	2,332	< or = to	2,332	0	O.K.		Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,240	< or = to	8,790	-6,550	O.K.	ok, religious consultant	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	151,550	equal to	151,550	0	O.K.		Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	329,061	equal to	329,061	0	O.K.		Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	52,807	equal to	52,807	0	O.K.		Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Professional Fees - pg. 3, column 8/Sch. F	58,163	equal to	58,163	0	O.K.									
Supp. Sched.- Benefit/Taxes	582,191	equal to	582,191	0	O.K.		Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	19,764	equal to	19,764	0	O.K.		Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	6,138	equal to	6,138	0	O.K.		Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	94,170	equal to	94,170	0	O.K.		Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	8,466	< or = to	61,150	-52,684	O.K.	ok	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	8,466	equal to	8,466	0	O.K.	ok employee meals	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.		Pg15 U29..U	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	6,497	equal to	7,306	-809	FAILED	ok, medicare days 6,497	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-808,254	equal to	-808,254	0	O.K.		Pg5 Z18	B.	34	1	Pg6 to Pg 6I	B.	14	8
Total loan balance	4,639,289	equal to	4,639,289	0	O.K.		Pg9 L34	A.	15	7	Pg17 V13+V2	N/A	29+39-41	2
Real estate tax accrual	114,000	equal to	114,000	0	O.K.		Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	416,126	equal to	416,126	0	O.K.		Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	5,933,664	equal to	5,933,664	0	O.K.		Pg12 to 12I	B.	36	4	Pg17 K26+K2	N/A	14 & 15	2
Equipment and vehicle cost	942,238	equal to	942,238	0	O.K.		Pg13 O22+L:	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	2,641,232	equal to	2,641,232	0	O.K.		Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	1,315,239	equal to	1,315,239	0	O.K.		Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	551,520	equal to	551,520	0	O.K.		Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.		Pg22 F31-J3	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,532,843	equal to	2,532,843	0	O.K.		Pg17:H41		25	1	Pg17 S41	N/A	48	1

Enter Cost Center Expenses	**YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINK**						
	TO THE COST REPORT!!		11/4/2005		12:21:27 PM		
HSA Number	?	Name	**Lexington Health Care Center-Bloomingdale**				
Cost report period	From:	01/01/03	To:	12/31/03		Base Number	336
If this is an ICF/DD 16 facility, enter a 1 in cell C		N					
Licensed bed days:	62,780	Occupancy:	49,860	Pct. of occupancy:	79.42%		
Illinois Public Aid Support Rate		$					
Genl Services Salary/Wage:	585,075	Col 1, Line 8 ---Audit Adj:					
Genl Admin Salary/Wage	580,327	Col 1, Line 28 ---Audit Adj:					
Total Salary Wage	3,801,323	Col 1, Line 44 ---Audit Adj:					
Employee Benefits	582,191	Col 8, Line 22 ---Audit Adj:					
Total General Services:	1,140,492	Col 8, Line 8 ---Audit Adj:					
Total General Admin	1,472,754	Col 8, Line 28 ---Audit Adj:					

Instructions and Calculation Steps

STEP Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to your total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8	$585,075
Divided by Total Wages (Column 1, Line 44	$3,801,323
General service wages as percent of total wages	15.3914%
Employee Benefits (Column 10, Line 22	$582,191
Allocation of Employee Benefits to General Services Costs	$89,607
Plus Total General Services (Column 10, Line 8	$1,140,492
New Total General Services Cost	$1,230,099

B. General Administration

1 Determine the proportion of General Administration wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringes amount for General Administration

3 Add the proportioned fringe amount to your total General Administration expenses

4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost

General Administration Wages (Column 1, Line 28	$580,327
Divided by Total Wages (Column 1, Line 45	$3,801,323
General administration wages as a percent of total wages	15.2664%
Employee Benefits (Column 10, Line 22	$582,191
Allocation of Emplayee Benefits to General Admin. Cost	$88,880
Plus Total General Administration (Column 10, Line 2	$1,472,754
Minus Total Fringe (Column 10, Line 2:	$582,191
New Total General Administration Cos	$979,443

STEP Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month	13 divided by 2 =	6.5
Beginning Day + Ending Day	32 divided by 60.8 =	0.526315789
Beginning Year + Ending Year =	206 multiplied by 6 =	1236
Sum of the three lines		1243.026316
Subtract from the sum		907.00
Base Number (expressed as a whole number, fraction dropped)		336

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier	1
General Administration Multiplie	1

C. Apply Inflation Multipliers to Update Cost

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table

New Total General Service Cost (Step I-A)	$1,230,099	
General Services Multiplier (Step II-B	1	
Updated General Services Cost		$1,230,099

2 Multiply New Total General Administration Cost (from Step I-B)by the appropriate multiplier from Table

New Total General Service Cost (Step I-B	$979,443	
General Administration Multiplier (Step II-E	1	
Updated General Services Cost		$979,443
3 Total Updated Support Costs (1 + 2		$2,209,542

STEP I Convert Total Updated Support Costs (C-3) to Per Diem Cost

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT CO $41.93

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14

Total Support Costs (Step II, C, 3, above	$2,209,542
Total Patient Days (Cost Report	49,860
Support Costs per Diem	$44.31

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5 Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above by your adjusted occupancy.

Licensed Bed Days	62,780
Multiplied by	0.93
	58,385
Minus total Patient Days	49,860
	8,525
One-third of difference	2,842
Plus Total Patient Day	49,860
Adjusted Occupancy	52,702
Total Support Costs (Step II, C, 3, above	$2,209,542
Divided by Adjusted Occupany	52702
Support Costs Per Diem	$41.93

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table I

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	#N/A
Minus Support Costs Per Diem	$41.93
Difference	#N/A
Multiply the Difference by	0.5
One-Half of the Difference	#N/A
Plus Support Costs Per Diem	$41.93
Support Rate if costs are between 35th and 75th percentile	#N/A

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	#N/A
Minus Support Costs Per Diem	$41.93
Difference	#N/A
Multiply the Difference by	0.5
One-Half of the Difference	#N/A
Compare one-half the difference to the profit ceiling for your HSA in Table II and	#N/A
Enter the Lower of the Two Amounts	#N/A
Plus Support Costs Per Diem	$41.93
Support Rate if support costs less than 35th percentile	#N/A

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above **#N/A**

75th Percentile is	#N/A
35th Percentile is	#N/A

Table
Inflation Multipliers

Base Number	General Services Multiplier	General Administration Multiplier
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table I
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	40.08	32.10	4.040
2	37.33	31.77	2.830
3	34.36	29.73	2.365
4	37.33	31.77	2.830
5	32.69	27.53	2.630
6	43.80	31.76	6.070
7	43.80	31.76	6.070
8	43.80	31.76	6.070
9	39.02	30.77	4.175
10	40.08	32.10	4.040
11	35.80	29.99	2.955

Table II (For ICF/DD 16 Facilities)
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

Capital Rate Data
Change print Orientation!

YOU HAVE CHOSEN THE CAPITAL CALC. THAT IS LINKED
TO THE COST REPORT!!!! 11/4/2005 12:21:27 PM
COSTS INCLUDED ON PAGES 12 THRU 12D START AT CELL O6

Facility Name: **Lexington Health Care Center-Bloomingdale** ID: **0035188**

HSA No.: ? Own or Rent? (O or R) ______ Own or Rent Beginning: ______

IF RENTED, have facilities been continously rented from an unrelated party since prior to January 1, 1978 (Y or N): or since the first day of operation for buildings constructed since January 1, 1978? N

Cost Report Pd:		Licensed Beds:	172	Total Patient Days	49,860
Begin	**01/01/03**	Licensed Bed Days:	62,780	% Occupied	79.42%
End	**12/31/03**			Capital Days	58,385

1989 Property Tax COST: ______ (Actual dollar amount 1989 taxes)

1991 Property Tax RATE: ______ (Inflated dollar amount divided by 1991 capital days)

FY 1991 Capital Rate: ______ (From form 787)

CAPITAL CALCULATIONS

	Calculation Column	
A. Determine the base year for your building from Work Table A	#REF!	
B. Determine the Building Specific historical cost per bed:		
1. Work Table A, Line 24, Column (B)	#REF!	
2. Total licensed beds from cost report Page 2, Line 7, column 3		172
3. Line 1 divided by Line 2	#REF!	
4. Regional construction inflator from Table 2	#N/A	
5. Building specific historical Cost ber bed (Line 3 * Line 4, round to even $)	#REF!	
C. Obtain the Uniform Building Value from Table 1	#REF!	
D. The capital rate will be calculated through a blending of the uniform building value from Line C and the building specific historical cost per bed from Line B5		
1. Building specific historical cost from Line B5	#REF!	
2. Uniform building value from Line C	#REF!	
3. Add Lines 1 and 2	#REF!	
4. Divide by 2 to obtain average	#REF!	
5. Enter 120% of line C	#REF!	
6. The blended value is the lesser of Line 4 or Line 5	#REF!	
E. Divide the blended value from step D by 339 days to obtain a per diem blended value investment	#REF!	
F. Multiply the per diem blended value from step E by the applicable rate of return to obtain the building rate factor. (The rate of return is 11% for 1979 and later base years and 9.13% for 1978 and older base years.)	#REF!	
G. Add $2.50 to Line F for equipment, rent, vehicle and working capital.		2.5
H. Add Lines F & G to obtain the preliminary capital rate	#REF!	
I. Implementation Capital Rate. (This step does not apply if the facility has been constructed or purchased after FY91.)		
1. Enter the FY 91 capital rate		0
2. Subtract the FY 91 property tax rate		0
3. FY 91 rate without tax		0
4. Multiply Line I3 by 115%	x 1.15%	
5. Implementation capital rate		0

J. Property Tax
Property taxes are taken from the Long Term Care Property Tax Statement which was submitted to the Department of Public Aid during FY93. Reimbursement for real estate taxes is based upon the actual 1991 taxes for which the nursing homes were assessed. The formula used is a follows:

1. Property Tax Expense (Long Term Care Property Tax Statement, Column D, Total.)		0
2. Divided by: Capital Days (see below)		58,385
3. Equals: Per Diem Cost		$0.00
4. Times: Property Tax Inflator (Table 3)	#N/A	
5. Equals: Updated Property Tax Cost	#N/A	

Capital Days
The capital days are the higher of the actual census (Page 2, Schedule III-B, Column 5, Line 14) or 93% of licensed bed days (page 2, Schedule III-A, Column 4, Line 7 * .93.)

1. Total Patient Days	49,860
2. Total Licensed Bed Days * .93	58385
3. Capital Days (higher of Line 1 or Line 2)	58,385

K. Total Capital Rate for FY 94

1. Enter the greater of the simplified system rate from Line H or the implementation capital rate from Line I	#REF!
2. Add Property Tax from Line J5	#N/A
3. Total capital rate (add Lines 1 & 2)	#REF!

WORK TABLE A

		Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
1	1	89	2980863	265296807	12
2	2	92	178974	16465608	12
3	3	94	2022894	190152036	12
4	4	0	0	0	12
5	5	0	0	0	12
6	6	89	9080	808120	12
7	7	90	3674	330660	12
8	8	91	2586	235326	12
9	9	92	3154	290168	12
10	10	93	1582	147126	12
11	11	94	15734	1478996	12
12	12	94	1381	129814	12
13	13	95	1074	102030	12
14	14	95	1288	122360	12
15	15	95	9433	896135	12
16	16	95	43839	4164705	12
17	17	0	0	0	12
18	18	96	8706	835776	12
19	19	96	7858	754368	12
20	20	97	3563	345611	12
21	21	97	12950	1256150	12
22	22	97	58806	5704182	12
23	23	97	1574	152678	12
24	24	98	76487	7495726	12
25	25	98	4506	441588	12
26	26	98	787	77126	12
27	27	98	9777	958146	12
28	28	99	718	71082	12
29	29	99	3296	326304	12
30	30	100	5748	574800	12
31	31	100	2534	253400	12
32	32	100	6307	630700	12
33	33	0	0	0	12
34	34	100	1300	130000	12A
35	35	#REF!	#REF!	#REF!	12A
36	36	101	3000	303000	12A
37	37	102	3050	311100	12A
38	38	102	3359	342618	12A
39	39	103	16450	1694350	12A
40	40	103	2900	298700	12A
41	41	103	4005	412515	12A
42	42	103	7188	740364	12A
43	43	103	59512	6129736	12A
44	44	103	16305	1679415	12A
45	45	103	75774	7804722	12A
46	46	103	8117	836051	12A
47	47	103	42698	4397894	12A
48	48	103	4800	494400	12A
49	49	0	0	0	12A
50	50	0	0	0	12A
51	51	0	0	0	12A
52	52	0	0	0	12A
53	53	0	0	0	12A
54	54	0	0	0	12A
55	55	0	0	0	12A
56	56	95	8606	817570	12A
57	57	96	7004	672384	12A
58	58	89	241	21449	12A
59	59	98	181	17738	12A
60	60	99	458	45342	12A
61	61	102	21400	2182800	12A
62	62	102	166493	16982286	12A
63	63	103	1650	169950	12A
64	64	0	0	0	12A
65	65	0	0	0	12A
66	66	0	0	0	12A
67	67	0	0	0	12B
68	68	0	0	0	12B
69	69	0	0	0	12B
70	70	0	0	0	12B
71	71	0	0	0	12B
72	72	0	0	0	12B
73	73	0	0	0	12B
74	74	0	0	0	12B
75	75	0	0	0	12B
76	76	0	0	0	12B
77	77	0	0	0	12B
78	78	0	0	0	12B
79	79	0	0	0	12B
80	80	0	0	0	12B
81	81	0	0	0	12B
82	82	0	0	0	12B
83	83	0	0	0	12B
84	84	0	0	0	12B
85	85	0	0	0	12B
86	86	0	0	0	12B
87	87	0	0	0	12B
88	88	0	0	0	12B
89	89	0	0	0	12B
90	90	0	0	0	12B
91	91	0	0	0	12B
92	92	0	0	0	12B
93	93	0	0	0	12B
94	94	0	0	0	12B
95	95	0	0	0	12B
96	96	0	0	0	12B

	Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
97	0	0	0	12B
98	0	0	0	12B
99	0	0	0	12C
100	0	0	0	12C
101	0	0	0	12C
102	0	0	0	12C
103	0	0	0	12C
104	0	0	0	12C
105	0	0	0	12C
106	0	0	0	12C
107	0	0	0	12C
108	0	0	0	12C
109	0	0	0	12C
110	0	0	0	12C
111	0	0	0	12C
112	0	0	0	12C
113	0	0	0	12C
114	0	0	0	12C
115	0	0	0	12C
116	0	0	0	12C
117	0	0	0	12C
118	0	0	0	12C
119	0	0	0	12C
120	0	0	0	12C
121	0	0	0	12C
122	0	0	0	12C
123	0	0	0	12C
124	0	0	0	12C
125	0	0	0	12C
126	0	0	0	12C
127	0	0	0	12C
128	0	0	0	12C
129	0	0	0	12C
130	0	0	0	12C
131	0	0	0	12D
132	0	0	0	12D
133	0	0	0	12D
134	0	0	0	12D
135	0	0	0	12D
136	0	0	0	12D
137	0	0	0	12D
138	0	0	0	12D
139	0	0	0	12D
140	0	0	0	12D
141	0	0	0	12D
142	0	0	0	12D
143	0	0	0	12D
144	0	0	0	12D
145	0	0	0	12D
146	0	0	0	12D
147	0	0	0	12D
148	0	0	0	12D
149	0	0	0	12D
150	0	0	0	12D
151	0	0	0	12D
152	0	0	0	12D
153	0	0	0	12D
154	0	0	0	12D
155	0	0	0	12D
156	0	0	0	12D
157	0	0	0	12D
158	0	0	0	12D
159	0	0	0	12D
160	0	0	0	12D
161	0	0	0	12D
162	0	0	0	12D

Base year:
Total of Column C/Total of Column B = Base Year

#REF! #REF! #REF!

Base Year = #REF!

TABLE 1 error

Table 1 Uniform building Value

	Uniform Building Value	
Base year	6, 7, 8 & 9	1, 2, 3, 4, 5, 10 & 11
1970	4114	3766
1971	5348	4896
1972	6583	6026
1973	7817	7155
1974	9051	8285
1975	10285	9415
1976	11519	10545
1977	12754	11675
1978	13988	12804
1979	15222	13934
1980	16456	15064
1981	17691	16194
1982	18925	17324
1983	20159	18453
1984	21393	19583
1985	22628	20713
1986	23862	21843
1987	25096	22973
1988	26330	24102
1989	27564	25232
1990	28799	26362
1991	30033	27492
1992	31267	28622
1993	32501	29751
1994	33736	30881
1995	34970	32011
1996	36204	33141
1997	37438	34271
1998	38673	35400
1999	39907	36530
2000	41141	37660

Use the 1970 values for all years prior to 1970

TABLE 2 #N/A

Construction Inflators by year and HSA
(Note: Use the 1960 Inflators for all years prior to 1960)
(For the FY94 Nursing Facility Rate Calculation Packet)

Year	1, 2 & 10	3, 4 & 5	11	6, 7, 8 & 9
1960	6.26	6.08	6.29	6.54
1961	5.67	5.52	5.66	5.87
1962	5.67	5.52	5.66	5.87
1963	5.67	5.52	5.66	5.87
1964	5.67	5.52	5.66	5.87
1965	5.67	5.52	5.66	5.87
1966	5.36	5.23	5.35	5.55
1967	5.1	4.97	5.08	5.28
1968	4.85	4.71	4.83	5.03
1969	4.61	4.48	4.59	4.79
1970	4.38	4.25	4.36	4.56
1971	4.01	3.89	3.98	4.15
1972	3.64	3.53	3.63	3.78
1973	3.36	3.26	3.36	3.48
1974	3.08	3	3.09	3.19
1975	2.83	2.77	2.8	2.91
1976	2.73	2.65	2.74	2.82
1977	2.57	2.48	2.55	2.68
1978	2.37	2.29	2.38	2.49
1979	2.18	2.12	2.21	2.32
1980	1.96	1.92	2.02	2.08
1981	1.8	1.76	1.86	1.91
1982	1.67	1.63	1.72	1.76
1983	1.54	1.5	1.57	1.65
1984	1.51	1.47	1.55	1.62
1985	1.48	1.45	1.5	1.59
1986	1.46	1.42	1.46	1.55
1987	1.44	1.4	1.43	1.52
1988	1.4	1.36	1.39	1.46
1989	1.35	1.33	1.35	1.41
1990	1.32	1.31	1.33	1.34
1991	1.29	1.29	1.3	1.31
1992	1.26	1.26	1.27	1.26
1993	1.25	1.24	1.25	1.23
1994	1.22	1.22	1.22	1.19
1995	1.2	1.2	1.19	1.17
1996	1.12	1.11	1.13	1.12
1997	1.1	1.09	1.1	1.1
1998	1.08	1.07	1.07	1.07
1999	1.04	1.04	1.04	1.04
2000	1.02	1.02	1.02	1.03
2001	1.00	1.00	1.00	1.00
2002	1.00	1.00	1.00	1.00

TABLE 3

Property Tax Inflator

HSA	Rate
1	1.05723
2	1.0395
3	1.0333
4	1.03302
5	1.03753
6	1.02368
7	1.02054
8	1.02613
9	1.01315
10	1.0815
11	1.03527

TABLE 4

Table 2 column

HSA	Column
1	1
2	1
3	2
4	2
5	2
6	4
7	4
8	4
9	4
10	1
11	3

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	253,678	30,363	12,348	296,389	0	296,389	0	296,389
2. Food Purchase	0	202,966	0	202,966	0	202,966	-8,466	194,500
3. Housekeeping	248,227	27,044	0	275,271	0	275,271	300	275,571
4. Laundry	38,067	16,279	0	54,346	0	54,346	-5,937	48,409
5. Heat and Other Utilities	0	0	153,903	153,903	0	153,903	3,003	156,906
6. Maintenance	45,103	0	120,425	165,528	0	165,528	3,189	168,717
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	585,075	276,652	286,676	1,148,403	0	1,148,403	-7,911	1,140,492
9. Medical Director	0	0	4,313	4,313	0	4,313	0	4,313
10. Nursing & Medical Records	2,395,964	180,655	62,035	2,638,654	0	2,638,654	0	2,638,654
10a. Therapy	0	0	594,308	594,308	0	594,308	0	594,308
11. Activities	145,881	10,689	2,332	158,902	0	158,902	0	158,902
12. Social Services	94,076	0	8,790	102,866	0	102,866	0	102,866
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	2,635,921	191,344	671,778	3,499,043	0	3,499,043	0	3,499,043
17. Administrative	151,550	0	329,061	480,611	0	480,611	-329,061	151,550
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	52,807	52,807	0	52,807	5,356	58,163
20. Fees, Subscriptions & Promotion	0	0	19,106	19,106	0	19,106	658	19,764
21. Clerical & General Office	428,777	28,513	24,644	481,934	0	481,934	13,215	495,149
22. Employee Benefits & Payroll	0	0	521,041	521,041	0	521,041	61,150	582,191
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	3,859	3,859	0	3,859	2,279	6,138
25. Other Admin. Staff Trans	0	0	2,160	2,160	0	2,160	7,527	9,687
26. Insurance-Prop.Liab.Malpractice	0	0	147,164	147,164	0	147,164	2,948	150,112
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	580,327	28,513	1,099,842	1,708,682	0	1,708,682	-235,928	1,472,754
29. Total General Administrative	3,801,323	496,509	2,058,296	6,356,128	0	6,356,128	-243,839	6,112,289
30. Depreciation	0	0	62,131	62,131	0	62,131	186,970	249,101
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	11,589	11,589	0	11,589	298,400	309,989
33. Real Estate	0	0	0	0	0	0	114,579	114,579
34. Rent - Facility & Grounds	0	0	1,073,102	1,073,102	0	1,073,102	-1,073,102	0
35. Rent - Equipment & Vehicles	0	0	2,404	2,404	0	2,404	3,268	5,672
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	1,149,226	1,149,226	0	1,149,226	-469,885	679,341
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	170,998	0	170,998	0	170,998	0	170,998
40. Barber and Beauty Shop	0	0	14,103	14,103	0	14,103	0	14,103
41. Coffee and Gift Shops	0	0	1,767	1,767	0	1,767	0	1,767
42. Provider Participation	0	0	94,170	94,170	0	94,170	0	94,170
43. Other (specify):*	0	0	55,151	55,151	0	55,151	-55,151	0
44. Total Special Cost Ce	0	170,998	165,191	336,189	0	336,189	-55,151	281,038
45. Grand Total	3,801,323	667,507	3,372,713	7,841,543	0	7,841,543	-768,875	7,072,668

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	-8,528	0
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,792,261	1,792,261
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	22,541	22,541
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	73,542	72,371
9. Other (specify):	0	0
10. Total current assets	1,879,816	1,887,173
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	53,269	53,269
13. Land	0	416,126
14. Buildings, at Historical Cost	0	5,182,731
15. Leasehold Improvements, Historical Cost	525,600	750,933
16. Equipment, at Historical Cost	400,805	942,238
17. Accumulated Depreciation (book methods)	-326,647	-2,641,232
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	82,034
24. Total Long-Term Assets	653,027	4,786,099
25. Total Assets	2,532,843	6,673,272
CURRENT LIABILITIES		
26. Accounts Payable	379,815	379,815
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	125,539	125,539
30. Accrued Salaries Payable	151,102	151,102
31. Accrued Taxes Payable	3,238	3,238
32. Accrued Real Estate Taxes	0	114,000
33. Accrued Interest Payable	0	37,334
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	557,910	230,360
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	1,217,604	1,041,388
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	4,513,750
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	373,482
45.Total Long-Term Liabilities	0	4,887,232
46.Total Liabilities	1,217,604	5,928,620
47.Total Equity	1,315,239	744,652
48.Total Liabilities and Equity	2,532,843	6,673,272

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	7,629,545
2. Discounts and Allowances for all Levels	-681,785
Subtotal - Inpatient Care	6,947,760
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	993,162
7. Oxygen	35,896
Subtotal - Anciliary Revenue	1,029,058
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	1,788
13. Barber and Beauty Care	15,469
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	33
16. Rental of Facility Space	0
17. Sale of Drugs	281,401
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	105,691
22. Laundry	5,937
Subtotal - Other Operating Revenue	410,319
24. Contributions	0
25. Interest and Other Investments Income	32
Subtotal - Non-Operating Revenue	32
27. Other Revenue (specify):	5,894
28. Other Revenue (specify):	0
Subtotal - Other Revenue	5,894
30. Total Revenue	8,393,063
31. General Services	1,148,403
32. Health Care	3,499,043
33. General Administration	1,708,682
34. Ownership	1,149,226
35. Special Cost Centers	242,019
35. Provider Participation Fee	94,170
37. Other	0
40. Total Expenses	7,841,543
41. Income Before Income Taxes	551,520
42. Income Taxes	0
43. Net Income or Loss for the Year	551,520

Page	
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
21	
22	
23	Provider Participation fee is linked from page 4